OPERATIONAL GUIDANCE FOR NATIONAL ROLL-OUT OF FAMILY HIV TESTING IN WEST AND CENTRAL AFRICA

Family Testing : A practical guide for implementation

World Health Organization
REGIONAL OFFICE FOR Africa

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A woman and her husband are taking an HIV test at the health center in the town of Guilgo in the West of Côte d'Ivoire.

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A Mother and her baby for routine checkup at the Mfuta Health Centre, Kisenga, Democratic Republic of the Congo

1 Why a Family Testing Operational Guide?

1.1 Background and context

West and Central Africa (WCA) is home to about 6 percent of the world's population and bears the second highest burden of the global HIV epidemic, with one-third of the new infections in children and adolescents globally occurring in WCA[i]. More than four decades into the HIV epidemic, three out of four of the 500,000 children aged 0-14 living with HIV in WCA are still not receiving life-saving antiretroviral therapy (ART)[ii], because the majority have not yet been tested for HIV. In WCA, only 2 out of 10 children in need of HIV testing received it within the first 2 months of life[iii]. The region's coverage of ART among children living with HIV (26%) is the second lowest in the world[iv]. Without antiretroviral treatment, up to 50 percent of HIV-infected children will die by their second birthday, with a peak mortality at 3 to 4 months of age[v,vi].

Various barriers prevent the scale-up of pediatric HIV testing and treatment including limited coverage of early infant diagnostic capacity, limited decentralization of pediatric treatment including task-shifting/sharing from pediatricians to nurses and to community actors, as well as prevalent HIV stigma at individual, family and community levels. In addition, all countries in the region face a low prevalence (range between 0.3% and 6.5%[vii]) generalized epidemic which requires targeted approaches that are tailored to this context and epidemic typology.

The WCA region has identified Family HIV Testing (hereinafter referred to as Family Testing) as a game changer that can deliver quick gains for the pediatric HIV response. Family Testing promotes access to HIV interventions for children who are often missed as they access routine primary health care services by starting with an individual family member who is living with HIV as an entry point to reach the entire family unit. Such an approach addresses several underlying factors that limit access to HIV testing services for family members, particularly children, such as stigma, fear of inadvertent disclosure of the parent's status, fear of blame, fear of emotional suffering of children and guilt[viii]; and also promotes effective linkage to HIV care and treatment. In addition, this approach provides an opportunity to facilitate access to wider health, nutritional and social services for the family, as needed.

The scientific literature indicates that Family Testing is an effective strategy for identifying children living with HIV (CLWHIV) in high HIV prevalence settings :

- In Malawi, almost half of HIV-positive clients enrolled in care had un-tested household members, many of whom were children and young persons[ix];

- In Uganda, the family centered model was found to be effective for achieving good Pediatric HIV intervention coverage and outcomes showcased by a 40-fold increase in children enrolled in HIV care in the 84 months following scale up of this approach[x];
- In Kenya, active referral of children of an index case was particularly effective in identifying older asymptomatic children, despite system and individual-level barriers affecting uptake of services[viii].

In low prevalence settings, Family Testing has also been found to be an effective strategy to identify CLWHIV:

- In Cameroon, a large study[xi] in 2017 evaluated six different entry points of pediatric testing in hospital facilities. Testing children of HIV-positive adults in care was found to be the most efficient way (22% yield) to identify children living with HIV as compared to testing children in TB services (11.4%), testing of children in prevention of mother-to-child transmission of HIV (PMTCT) services (6.1%), testing children admitted in pediatric wards (5.6%), testing children in out-patient services (0.1%) and testing children in immunization services (0%).
- In Togo, it was demonstrated that Family Testing is complimentary to a provider-initiated testing and counseling (PITC) strategy that uses multiple entry points to test children. Testing uptake for children increased three-fold over a two-year period of PITC including Family Testing roll-out. Yields from testing through TB clinics, Family Testing, out-patient departments, in-patient wards, PMTCT services and immunization services were 19%, 9%, 8%, 7%, 5% and 5% respectively[xii].
- In Democratic Republic of Congo (DRC), systematic Family Testing multiplied by 4 the rate at which HIV-positive children were identified over a period of six months. In addition, children were identified at a less advanced clinical stage[xiii].
- There are several programmatic experiences from the West and Central Africa region including from Burkina Faso, Cameroun, Central African Republic (CAR), Chad, Cote d'Ivoire, DRC, Nigeria, Senegal, Sierra Leone and Togo confirming that :
  i. Family Testing is feasible and acceptable to clients and their families and is an effective case finding strategy for pediatric HIV.
  ii. Linkage to treatment (the ultimate goal) has been successful across all country experiences

While countries strive to increase their capacity to decentralize early HIV testing – including through point-of-care diagnostic technology -, it is imperative to better engage family and community members in the treatment and care of children and adolescents living with HIV. Bringing a «Family-Centered Approach» to our HIV programming in the region through Family Testing would help achieve two objectives:

1. Early identification of HIV-positive children and adolescents;
2. Linkage to- and retention of children, adolescents and their families in HIV care services.

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A 21 years old seropositive mother in Côte d'Ivoire is visiting the health center of her village to get her medication.

1.2 Purpose of the operational guidance

This operational guidance is meant for use by national programme managers, implementers, advocates and health care providers in collaboration with partners, supported by national, regional and global experts. The guidance draws off the experience in Family Testing from within and outside WCA and combines recommendations from the Dakar Expert consultation meeting which took place in June 2018 as well as lessons learnt from the pilot of the Family Testing operational guidance in Liberia in June 2018. It is a living document which will be enriched as evidence on Family Testing in the region grows. The use of this guidance will be complemented by a toolkit and a community of practice.

It is a regional document drafted for the countries in West and Central Africa to guide country teams to design country-contextualized family HIV testing roll-out with a focus on reaching the missed children and adolescents and putting them on treatment, in order for them to survive, thrive and live healthy fulfilling lives.

2 Family Testing in a nutshell

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A 26 years old boy smiles when he learned he's HIV negative. At his home, in Ndjamena, the capital of Chad.

2.1 What is Family Testing?

By Family Testing we refer to the offer and provision of HIV testing to family members (children and partners) of a person diagnosed with HIV – also called "index case" -, with linkage to treatment and care for family members identified HIV positive. WHO defines index testing as "a focused approach to HIV testing in which the household and family members (including children) of people diagnosed with HIV are offered testing"[xiv]. In this guide Family Testing replaces the use of the terminology «index testing» and describes the targeted testing of families and household members of a person living with HIV (adult or child) who has been recently diagnosed or is already in care and treatment.

The linkage to care component of Family Testing is critical as it refers to family members' access to antiretroviral treatment (ART), to other basic health and social services and to the psychological support for families, particularly as it relates to disclosure among family members, including children.

2.2 Four components of Family Testing

1. Identification of family members of a person (adult or child) newly diagnosed or in HIV care and treatment services;
2. Offer of HIV testing to family members with un-known status;
3. Communication of results in an age-appropriate manner to family members and facilitating disclosure;
4. Linkage to care and treatment, support for adherence as well as linkage to other health and social services as needed

For each of these components, it will be important to answer critical questions relating to who can play a role (including identifying how to engage community actors), the location where the service can be delivered, the tools needed and the possible challenges to anticipate. Throughout these steps it will be critical to ensure that all services meet the WHO 5 Cs Principles for HIV Testing and Counseling Services[xv] : i) Consent, ii) Confidentiality, iii) Counselling, iv) Correct test results and v) Connection to care and treatment. In addition, issues relating to patient's refusal should be promptly identified and addressed.

Critical questions

- Who should do Family Testing ?

- Who provides the counselling and testing largely depends on a trust relationship being established between the provider and the person living with HIV. This will be key to the success of bringing family members for an HIV test. The counselling can be provided by either health staff already in contact with patients or community workers, particularly those living with HIV, who will know best the difficulties as well as the importance of Family Testing. Both health care providers and community workers will have to be trained on providing counselling for Family Testing. The PEPFAR/USAID/CDC/DOD/WHO standard operating procedure (SOP) on partner and family-based index case testing is a resource that can be adapted to deliver this training.[xvi]

- On the specific role of community workers in counselling for Family Testing, many have been trained on voluntary counselling and testing. They are a powerful human resource to tap into, especially when building on existing community initiatives, as health providers often lack the time and presence to deliver detailed counselling. Social workers and psychologists can also be brought on board as, like community workers, they tend to be familiar with the day-to-day issues faced by vulnerable families, including those affected by HIV.

- Where should Family Testing take place?

- For each district selected, it will be critical to agree on the sites where Family Testing will take place, starting with adult and children living with HIV who are on treatment. These may be health settings (hospitals, clinic, pediatric wards, etc.) or community settings (offices of associations of people living with HIV, community centers, key population centers, mobile clinics, door-to-door outreach, schools and other educational establishments, workplaces, places of worship, parks, bars and other venues).

- The home-based testing option is an effective and fast way to ensure that all family members (including male partners) are tested. This option should be considered including any necessary adjustment relating to family privacy, appropriate counselling and procedures, as stigma associated with HIV tends to be a key concern. Providing Family Testing as an intervention that is bundled within a package of essential health services such as immunization, nutrition screening and supplementation, tuberculosis screening and early childhood development milestone examination, is one approach to be considered.

- HIV self-testing (HIVST) - an emerging approach - is a process in which an individual who wants to know his or her HIV status collects a specimen, performs a test and interprets the result by him or herself, often in private. Self-testing is an option that also needs to be considered for the populations with low access (adolescents) and for the particularly stigmatized and vulnerable populations such as sex workers, men who have sex with men, injecting drug users and migrants.

- What tools are needed for Family Testing?

There are several tools that exist from pilot and implementation experiences within and beyond WCA. These are available through a web-based toolkit for national adaptation. They include :

- Family tree tool
- Family referral forms
- Family Testing counseling guide
- Family Testing screening form
- Family Testing outcome form
- Family Testing/index client register
- Family Testing reporting form
- Facility-based Family Testing standard operating procedure (SOP)

- What challenges and barriers to Family Testing should we anticipate?

Several barriers and challenges may exist, and these can be categorized as relating to the individual and relating to systems (table 1) or can be categorized according to thematic area (table 2).

Table 1 : Individual and System level barriers[viii (p6)]

Individual Level		Systems Level	
Barriers	Solutions	Barriers	Solutions
Fear of inadvertent disclosure/stigma	Disclosure support, peer support mechanisms	Inconsistent inquiry & offering of testing	Systematic assessment and active referral with supportive tools & quality standards
Low parent awareness of benefits	Education on benefits of early identification and treatment for children	Health worker overwhelm with increased testing load	Training, task shifting and review of client flow
Unwillingness of parents due to fear, guilt, blame	Psychosocial support to address fears, guilt and blame	Poor linkages to treatment/poor referral systems	Establish active follow up/tracking mechanisms to ensure prompt treatment initiation and retention
Logistical challenges of bringing children/family to the facility (transport cost, time off work)	Address logistical challenges based on context (home based testing, transport reimbursement)	HIV testing commodities/ART stock outs	Strengthen supply chain, forecasting & quantification

Table 2 : Challenge Areas in Family Testing[xvii]

Challenge Area	Key Considerations
Demand side: care seeking behaviour	overcoming stigma and discrimination, raising awareness and creating demand
Demand side: psychosocial support	supporting disclosure within the family unit, promoting confidentiality, providing age-appropriate counselling
Demand side: gender and human rights related issues	promoting male participation, identifying and addressing inter-partner violence and criminalization issues
Supply side: human resources capacity for quality care	capacity for decentralized and differentiated pediatric HIV service delivery, task shifting and task sharing, empowering of lay providers
Supply side: care continuum, retention, mulitisectorality	timely linkage to treatment, tracking and follow-up for those delayed or lost from care, linkages to other health and social services.
Supply side: Supply chain, monitoring and evaluation	Good stock control records management, forecasting and quantification to ensure consistent availability of commodities and drugs, adequate tools for recording and reporting, regular data reviews.

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Peer counselor at the Ebolowa Regional Hospital in Cameroon counsels a mother when she receives her HIV test results.

2.3 Enablers for Family Testing

An enabling environment requires the presence of factors at community, health facility and health system levels (table 3) to mitigate potential barriers and challenges.

Table 3 : Enablers for Family Testing

Family Testing enablers at community, health facility and health system levels
Community Enablers
- Positive advocacy from community, traditional, religious and civic leaders - Active networks of people living with HIV and civil society - Active and accessible peer-support groups - Empowered and trained community health workers
Health Facility Enablers
- Good appointment and card filing/retrieval systems to shorten waiting time and enhance client satisfaction - Multiple-entry point testing through various health service entry points to complement Family Testing - An established system for patient follow-up using both community workers and health facility workers supported by peer support groups (mentor mothers, adolescent youth groups) - Linkage to other services such as TB family screening, nutritional family screening, early childhood development (ECD) services, cash transfers and supplementary food programs
Health System Enablers
- Family Testing policy, guidance and tools - Regular supervision and mentorship - Strong supply chain management for testing commodities and antiretroviral drugs (ARVs) - Testing quality control/quality assurance systems - Skills building for disclosure. - Task shifting and equipping CHWs with training & tools to conduct counselling and testing - Functional referral systems - Linkages to social welfare and gender-based violence programs (the HIV and Child Protection policy and programming brief is a useful resource)

3 Implementing, monitoring and sustaining Family Testing: 12-steps for national roll-out

12-steps for national roll-out of Family Testing

1. **Build national ownership** through awareness raising and obtaining buy-in from key stakeholders.
2. **Assess the situation in the context** of differentiated HIV testing for children
3. **Define a social behavior change and communication strategy** that targets families, communities, health-workers, advocates and leaders.
4. **Conduct a national consultation** to develop a national costed plan of action and develop/ adapt national tools for service delivery, supply chain management, community engagement, communication, advocacy, and monitoring.
5. **Leverage resources** through existing and potential funding mechanisms (Global Fund (GF), Global Financing Facility (GFF), Private Sector, National Budget).
6. **Leverage innovation** through use of existing technological platforms (U-report, m-health) and service delivery advances (point-of-care diagnostics, self-testing, tele-medicine).
7. **Build capacity** for implementation through training, mentoring and supervision, focusing first on regions with the largest testing and treatment gaps.
8. **Deliver Family Testing within a package of differentiated HIV testing services** to optimize all child health entry points at community and facility levels
9. **Foster integration and multisectoral collaboration** for holistic care by creating linkages to other services and sectors
10. **Activate Family Testing** in focus regions through high-level press events to garner visibility and momentum.
11. **Monitor and Evaluate for Learning**: by taking an evaluative monitoring approach.
12. **Exchange knowledge** by documenting and sharing experiences.

3.1 Building national ownership

National ownership is critical for the success of Family Testing. Family Testing involves several key stakeholders, each with a role to play.

As an initial step to implementing Family Testing, the key national stakeholders will need to be convened to conduct awareness raising and obtain buy-in on Family Testing. A steering committee should then be formed with representation from these key stakeholders.

The steering committee will provide stewardship and oversight for the 12-steps of national roll out of Family Testing.

Some of the critical tasks of the steering committee will be to:

- establish that an enabling policy and legal framework exists for Family Testing roll-out;
- identify national and sub-national champions;
- establish cross-sectoral engagement in order to leverage additional family support services beyond HIV testing and treatment;
- establish agreement on modalities for public-private collaboration; and
- identify opportunities to build on such as campaigns targeting families' health or First Ladies' Free to Shine campaigns which would present a great opportunity to raise the profile of Family Testing

3.2 Assessing the situation

Assessing the situation is a critical step that will inform planning for Family Testing. Assessment pertains ensuring that there is an enabling environment with a supportive policy and legal framework; reviewing data to understand the distribution of un-identified and un-treated children to inform geographic prioritization; mapping differentiated testing service delivery models for children; and exploring the barriers at the levels of family, community, health services and national systems to understand best the change that needs to happen to facilitate successful Family Testing roll-out.

Key Family Testing Stakeholders

- *Heads of household,*
- *Male members of household*
- *Community and traditional leaders*
- *Networks of People living with HIV (NPLHIV)*
- *Peer Groups*
- *Religious leaders*
- *Political leaders*
- *Human rights and legal bodies (including gender-based violence (GBV) focal points)*
- *Psychosocial counselors*
- *Community Health Workers*
- *Social Workers*
- *Health Care Providers (Nurses, Doctors, Laboratory Technicians, Pharmacists)*
- *National AIDS Commissions (NAC)*
- *National AIDS Control Programmes (NACP)*
- *Ministries of Health (MOHs) including National Program Managers (for PMTCT, ART, MNCH/EPI, Nutrition, TB, Community Systems, Health Promotion, M&E)*
- *Other line ministries (Gender, Social Welfare, Education)*
- *Faith based organizations (FBOs)*
- *Community based organizations (CBOs)*
- *Civil society organizations (CSOs)*
- *Children's and adolescents' associations*
- *Implementing, bilateral and multilateral partners*
- *Private sector*
- *Donors*

Assessing an enabling environment : review the national legal and policy framework for Family Testing

1. a) Does the HIV legal and policy framework promote the following?	❒ Provider Initiated Testing and Counseling (PITC) ❒ Partner notification ❒ HIV disclosure to sexual partners and to children
b) Where gaps exist can we modify, adapt or revise what is in existence to address these gaps?	❒ HIV disclosure to sexual partners and to children ❒ Non-criminalization of HIV

2. a) Do the HIV testing and related guidelines support the following?	❒ Family Testing ❒ PITC ❒ Task shifting for HIV testing, including for children ❒ Community/home-based testing ❒ Self-testing ❒ Age of consent for adolescents ❒ Intimate partner violence / protection of people living with HIV
b) Where gaps exist can we modify, adapt or revise existing guidelines to address these gaps?	

Assessing distribution of burden for geographic prioritization: review the data to define the testing and treatment gap for children at national and subnational levels

Using the global AIDS monitoring (GAM) report, national health management information system (HMIS) reports, pediatric HIV situation analyses, the catch-up plan, and service delivery reports for differentiated testing, conduct a rapid assessment of the following aspects:

3 What is the current pediatric HIV treatment gap?

- Nil
- <20%
- 20-40%
- 41-60%
- 61-80%
- >80%

4. What pediatric targets were set out in the national catch-up plan?

If none – please review and agree on what these could be, based on data from the pediatric acceleration plan

5. Identify priority districts for HIV pediatric care?

Before rolling out Family Testing, it is important to identify priority districts and sites of intervention. Ideally, these should be where the burden of HIV is the largest, where there are large unmet needs for testing and treatment of children and where there are large cohorts of people living with HIV on ART. It is useful to refer to eMTCT and pediatric plans if these were developed at national level, to align with priority districts that were already selected.

6. Review the testing and treatment gaps by sub-population and geographic location with available data for 90-90-90 disaggregated by age-group and subnational region. Are there any specific considerations for context such as geographic barriers, natural disasters and civic unrest?

INDICATOR	ESTIMATED NEED	2020	NUMBER REACHED	COVERAGE	YEAR (Source)
Adults living with HIV knowing their status					
Adults living with HIV receiving ART					
Adults living with HIV receiving ART and tested for viral load					
Adults living with HIV receiving ART and virally suppressed					
Pregnant women receiving an HIV test					
Pregnant women living with HIV receiving ART					
Pregnant women living with HIV receiving ART and tested for viral load					
Pregnant women living with HIV receiving ART and virally suppressed					
HIV exposed infants receiving early infant diagnosis within 2 months					
Children aged 0-14 living with HIV knowing their status					
Children aged 0-14 living with HIV receiving ART					

INDICATOR	ESTIMATED NEED	2020	NUMBER REACHED	COVERAGE	YEAR (Source)
Children aged 0-14 living with HIV receiving ART and tested for viral load					
Children aged 0-14 living with HIV receiving ART and virally suppressed					
Adolescents aged 10-14 living with HIV knowing their status					
Adolescents aged 10-14 living with HIV receiving ART					
Adolescents aged 10-14 living with HIV receiving ART and tested for viral load					
Adolescents aged 10-14 living with HIV receiving ART and virally suppressed					
Adolescents aged 15-19 living with HIV knowing their status					
Adolescents aged 15-19 living with HIV receiving ART					
Adolescents aged 15-19 living with HIV receiving ART and tested for viral load					
Adolescents aged 15-19 living with HIV receiving ART and virally suppressed					

Assessing differentiated service delivery models: review the level of implementation of differentiated testing for children

7. What are the current strategies being implemented to find and test children?	❒ Early infant diagnosis ❒ Testing in immunization clinics ❒ Testing in pediatric admission wards ❒ Testing in out-patient services ❒ Testing for children under care for malnutrition ❒ Testing for children under care for tuberculosis ❒ Testing in integrated management of childhood illnesses (IMCI) and integrated community case management (iCCM ❒ Family Testing

8. What is their level of implementation in health facilities and within the community?	Early infant diagnosis: ■ Nil ■ pilot ■ <20% ■ 20-50% ■ 51-70% ■ At scale Testing in immunization clinics: ■ Nil ■ pilot ■ <20% ■ 20-50% ■ 51-70% ■ At scale Testing in pediatric admission wards: ■ Nil ■ pilote ■ <20% ■ 20-50% ■ 51-70% ■ At scale Testing in out-patient services ■ Nil ■ pilote ■ <20% ■ 20-50% ■ 51-70% ■ At scale Testing in children under care for malnutrition: ■ Nil ■ pilote ■ <20% ■ 20-50% ■ 51-70% ■ At scale Testing in children under care for tuberculosis: ■ Nil ■ pilote ■ <20% ■ 20-50% ■ 51-70% ■ At scale Testing in integrated management of childhood illnesses (IMCI) and integrated community case management (iCCM) ■ Nil ■ pilote ■ <20% ■ 20-50% ■ 51-70% ■ At scale Family Testing: ■ Nil ■ pilote ■ <20% ■ 20-50% ■ 51-70% ■ At scale

9. What are the testing yields for each approach (use any available data and state the source)?	Early infant diagnosis: ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50% Testing in immunization clinics: ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50% Testing in pediatric admission wards: ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50% Testing in out-patient services: ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50% Testing in children under care for malnutrition: ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50% Testing in children under care for tuberculosis: ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50% Testing in integrated management of childhood illnesses (IMCI) and integrated community case management (iCCM): ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50% Family Testing ■ <1% ■ 1-5% ■ 6-10% ■ 11-20% ■ 21-50% ■ >50%

This differentiated service delivery review will highlight the extent to which various child centred entry points are being optimized for case finding. This should inform planning for case-finding systems strengthening actions for these entry points (such as training, mentoring and supervision) to be integrated within the Family Testing roll-out effort..

Assessing bottlenecks to change: conduct a barrier analysis

10. Define barriers at all levels (family, community, health services, national systems); in the four components of Family Testing:
    - Identification of family members of a person (adult or child) newly diagnosed or in HIV care and treatment services;
    - Offer of HIV testing to family members with un-known status;
    - Communication of results in an age-appropriate manner to family members;
    - Linkage to care and treatment, support for adherence as well as linkage to other health and social services as needed
11. Transform the barriers into "the change we want to see" (and that can be achieved through feasible strategies);
12. Define indicators that allow the measurement of change (early outcomes on knowledge, beliefs, perceptions, understanding, attitudes, behaviors, services and policies);
13. Project and suggest feasible strategies (based on existing resources) for promoting the change; and
14. Identify who the main duty bearers that can influence Family Testing are? What roles are they expected to play in enabling family testing and supporting adherence to care and treatment? What are the main barriers and motivating factors for them to fulfill their roles at the family, community, health services and national systems level?

This rapid assessment should provide in-depth understanding of implementation status of Family Testing in the context of the policy and legal framework, the subnational unmet need and regions for geographic prioritization, differentiated testing service delivery models for children, and key barriers to be addressed for successful national roll-out of Family Testing.

3.3 Defining a social behaviour change communication (SBCC) strategy

Relevance of a short-term targeted campaign and a comprehensive SBCC programme?

The main focus of change is a one-spot positive decision of a PLHIV to engage his/her family members in HIV testing and care. Campaigns play an important role in SBCC and they have shown capacity to generate results in creating demand for services, especially when they promote a one-time behavior. Since one-off campaigns are useful for focusing people's attention on newly introduced interventions, an initial campaign would make much sense in the context of the introduction of Family Testing. Additional campaigns may be needed throughout the life of the programme. However, the decision of using campaigns should not be pre-empted and we may find particular situations where a campaign is not needed or opportune. The analysis, the programme goals and the SBCC strategy approaches determine the need for a communication campaign and its role.

Despite the strategic importance of campaigns, generating demand for Family Testing should be conceived as a sustained programme that addresses the barriers at different levels and combines them with sustained communication interventions where dialogue and interpersonal communication play a central role. The reasons for this are:

- Campaigns cannot be sustained in time and are exposed to audience and stakeholders' fatigue. They often result in a rapid increase of behavior adoption, but after some time adoption rates may plateau or even decrease.
- HIV programmes are in need of a permanent communication interface with

the population so that new "generations" of participant groups are reached as they become concerned by HIV.

- Whilst engagement in family testing is a one-time behavior, sustained engagement in care and treatment is also a behavior to be promoted within the framework of Family Testing. Widespread negative societal perceptions and stigmatization of PLHIV are barriers to the positive decision of the PLHIV and the involvement of family members in HIV testing. This is in particular the experience of countries in WCA as opposed to East and Southern African (ESA) countries where the HIV prevalence is high. Although a short-term campaign can contribute to reducing these negative perceptions and stigma, only longer-term more comprehensive SBCC strategies, leveraging the potential of a variety of mutually reinforcing communication channels, can considerably generate sustainable social and behavior change.

For these reasons, the planning of a more sustained and comprehensive approach creating the positive supporting environment (societal, institutional, legal and political) and contributing to system strengthening, should be considered when designing communication support to the roll-out of Family Testing.

Main components of a comprehensive SBCC strategy

- Targeted SBCC

- Conveyed by community-based change agents through interpersonal communication (IPC);
- Complemented by proximity media (community radio, drama for development, etc.)
- Design and implementation of tailored communication approaches for vulnerable groups or geographical areas with the poorest family testing rates, with a stronger component of community engagement/ participation.

- Community mobilization and engagement:

- Mobilizing leaders (mayors, CSO leaders, religious leaders) to engage their constituencies to support Family Testing.

- Mass media campaign for creating a favorable environment

- Encouraging positive decision making of people living with HIV (PLHIV) to reach out to their family members and networks.

Developing the SBCC strategy

There are different planning models or processes that can be applied for the planning and implementation of a SBCC strategy. All of them share a number of steps that can be summarized as follows:

- Data collection and analysis.
- Strategic design.
- Development and testing of messages and materials.
- Implementation and monitoring.
- Evaluation and re-planning

This section puts the focus on the three first steps. While some elements in the data collection and analysis and strategic steps have been considered throughout the process described so far in this document, at the moment of developing the SBCC strategy all relevant information produced should be consolidated and completed following the elements listed below:

Step 1. Collect and analyze data for a communication analysis

This includes:

- Problem and programme analysis.
- Communication environment analysis.
- Participant audience analysis.
- Behavioral barrier analysis.
- Channel analysis.

Step 2. Design the strategic communication plan

- Formulate goals and objectives.
- Establish SMART communication/ behavioral objectives and results.
- Define strategic approaches and implementation modalities, including linking-up influential actors to the right communication channel/activity for social mobilization.

Step 3. Design the creative strategy

- Formulate key messages for different participant/audience groups.
- Determine creative approaches, channels and media.
- Develop/customize existing IEC materials.

Further guidance for following these steps is provided in the toolkit for the roll-out of Family Testing in WCA.

When going through this process, it is important to keep in mind that it is paramount for the SBCC programme to maximize the available resources and build on the integration with different existing programmes and assets. To this regard, the communication environment analysis can help us map the existing capacities and approaches which SBCC for Family Testing can build on including current communication strategies linked to HIV, TB, nutrition, immunization and other national health or child survival primary health care programmes.

3.4 Conducting a national consultation

Conduct a 2 to 3-day national consultation that should bring together all stakeholders involved in HIV programming from the national level with some representation from the target subnational levels, including PLHIV, CSO, FBO, community associations, child and adolescent associations, outreach workers, facility-based service providers, programme managers, representatives of the National AIDS Commission (NAC), National AIDS Control Programme (NACP), other Ministry of Health (MOH) programmes such as TB, Malaria, Nutrition and immunization, as well as representatives from UNICEF, UNAIDS and WHO. It should be facilitated by a team of national, regional and global Health, HIV and C4D/SBCC experts.

The main output of this consultation is a draft costed implementation plan for Family Testing. This national planning process should be complemented by development of sub-national plans in the target districts, counties or local government authority's (LGA's) by conducting similar 2-3-day consultations at this level.

The national consultation should also complete the following outputs:

a. Adaptation of job-aids, recording, reporting and monitoring tools.

b. Development/adaptation of communication and advocacy messages, and communication and community engagement plans.

c. Adaptation of training materials and development of a training plan for key stakeholders and implementers.

d. Conducting of an exercise to review testing commodity and antiretroviral drug (ARV) stocks to inform procurement and pre-positioning as needed.

e. Adaptation of this regional guidance to the national context

Successful implementation of the national and subnational plans will ensure that leaders, providers and community members have been trained; communities and families have been mobilized through use of mass and print media, social mobilization as well as interpersonal communication; and health facilities and community points of service delivery have been organized and stocked with job-aids, monitoring tools, testing commodities and ARV drugs with back up supplies and means of delivery in place.

3.5 Leveraging resources

Map and understand the funding opportunities in-country

Current financing or donor support mechanisms for the HIV response in the WCA region include The Global Fund (GF), The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), UNITAID-funded CHAI-UNICEF POC project, UNICEF-funded POC project, the UNICEF French National Committee. Other MNCH-focused funding such as the World Bank's Global Financing Facility (GFF) as well as bilateral funding mechanisms may also be leveraged for HIV programming.

While each funding mechanism has its own set guidelines, opportunities to leverage these resources for Family Testing should be explored. In addition, national planning and budgeting processes should be utilized to allocate resources for Family Testing.

Integrate Family Testing in already planned investment and expenditure

Some of the components required for Family Testing are likely already covered through existing financing streams such as for rapid HIV testing commodities, point of care/near point of care diagnostic devices and commodities, antiretroviral drugs and formulations. Other components could be integrated in already planned expenditures for acceleration of the first 90 such as training, mentoring, supervision, community engagement and communication and advocacy. A few critical components may require specific funding such as the development/ adaptation of Family Testing tools.

Prioritize and target

Take a phased approach to national roll-out by prioritizing focus based on highest need (where the largest subnational testing and treatment gaps for children are) and targeting the available resources to these prioritized regions.

3.6 Leveraging innovation

Opportunities to leverage innovation for Family Testing include:

1. Electronic community registers: for real-time tracking and use in reaching out to families.
2. U-report technology: i) to measure reach and coverage of the programme including high-level press events; ii) to obtain real-time feedback on quality of services and iii) to assess knowledge.
3. Technological applications (apps) to provide easy access to information and counseling guides.
4. Mobile money to pay transport allowances/ reimbursements during implementation/campaigns.

Suggested actions for increasing Family Testing:

Taking advantage of the fact that mobile phones are widespread, even in most remote communities; and building on existing initiatives around M-Health as well as on youth's high engagement in social media platforms; some actions to consider are:

- Creating a specific U-report for people living with HIV.
- Using electronic voices to address high levels of illiteracy in some populations.
- Setting up a family harmonized appointment system.
- Developing linkages with community observatories – e.g. inter-personal communication to address stockouts and planning.
- Sending text messages to follow-up with caregivers on children's health, appointments, treatment, etc.
- Monitoring community health centers.
- Linking-up technologies with self-testing (text messages, etc.).

Important considerations

- Confidentiality of data - devices are encrypted, and data fully secured. Addressing privacy and security in digital development involves careful consideration of which data are collected and how data are acquired, used, stored and shared.
- Many patients give wrong numbers due to fear of stigma.
- Language needs to be adapted to local contexts.
- Communication costs need to be factored in – platforms are open source and free however estimated budget relates to communication and depends on how many people you want to contact/connect.
- Build sustainable platforms and digital connections to maintain user and stakeholder support, as well as to maximize long-term impact. Systems need to be operated within a government system.

3.7 Building capacity

Training

– Assess human resource needs for service delivery
  - Review/modify task shifting/ task sharing policy for HIV testing and ART initiation

– Assess training needs and resources
  - Review training needs for:

- Interpersonal communication
- Psychosocial counseling
- Disclosure counseling
- Child and adolescent counseling and disclosure counseling
- HIV Testing
- ART initiation
- Barriers to testing uptake (stigma, non-disclosure, low awareness of treatment availability)
- Dealing with negative consequences of positive results (violence (gender-based violence (GBV), violence against children (VAC), isolation, denial)
- Review/ modify/ develop training curricula
- identify and capacity build resource persons

– Conduct training at facility and community levels
  - Conduct targeted training of health-facility and community workers based on identified training need
  - Conduct targeted orientation of health-facility and community workers on other HIV-sensitive health and social needs of families affected by HIV (TB screening and preventive therapy, nutrition screening and support, early childhood development support, social cash transfers, adolescent and youth skills building programmes)

Mentoring and supervision

Conducting regular mentoring and supervision is critical to strengthen skills and systems for successful Family Testing, as well as ensure provision of quality services. This could be structured to be focused and frequent in the initial stages to ensure adequate support to strengthen capacity. Once Family Testing is well established, this process can be integrated on existing routine mentoring and supervision mechanisms.

3.8 Delivering Family Testing within a package of differentiated HIV testing services

According to WHO[xviii], a strategic mix of approaches should be used to deliver HIV testing services by facilitating the diagnosis of as many people as possible as early as possible aiming to maximize yield, efficiency, cost-effectiveness and equity. This mix of approaches depends on "the organization of the health system, local context, epidemiology, current testing coverage and available financial and human resources as well as what the intended clients want"[xix].

Four approaches together represent the range of options to differentiate HIV testing services[xx]: facility-based approaches, community-based approaches, partner notification services and HIV self-testing. Family Testing cuts across the four dimensions of differentiated HIV testing (figure 1) as successful implementation of Family Testing is built off identifying a person living with HIV through multiple service delivery entry points that are facilty- or community-based; and offering facility- or community-based HIV testing to family members including through the options of partner notification and self-testing (for relevant sub-populations).

Figure 1: Family Testing in the context of Differentiated HIV Testing

Facility-based approaches: A provider routinely offers testing and counselling (PITC) through an established testing site that is either stand-alone or integrated within a clinical setting (i.e. voluntary counselling and testing (VCT) sites) [xxi]. For children, multiple entry points should be targeted (i.e. PMTCT/EID, nutrition, TB, pediatric ward and out-patient service delivery points).

Community-based approaches: Testing is conducted in the natural setting of the community member through mobile outreach, home-based services, bars, clubs, taxi-ranks, places of worship, social networks and HIV-specific or multi-disease campaigns.[xxii]

FAMILY TESTING

Assisted/passive partner notification services: All persons diagnosed with HIV should be offered voluntary HIV partner notification by a trained provider at the time of diagnosis and throughout their interaction with treatment and care services. Passive partner notification is when the provider encourages the client to disclose their status to their partner themselves, while active partner notification is when the provider assists the client to notify the partner/s using contact referral, provider referral or dual referral approaches[xxiii].

HIV self-testing (HIVST): When a person wants to know their status, s/he can collect a specimen, perform the test, and interpret their own result. HIVST approaches can be largely facility- or community-based, implemented through secondary distribution (delivered by sexual partners), integrated with other health programmes or provided through pharmacies, vending machines or other public and private channels[xxiv].

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A family is undergoing a home screening HIV test in the village of Benjaminkro, in the Southwest of Côte d'ivoire.

3.9 Fostering integration and multisectoral collaboration

Prevention of mother-to-child transmission of HIV (PMTCT) services delivered within maternal newborn and child health (MNCH) settings are the premier entry point to deliver Family Testing. Integrating testing for HIV in antenatal care services is cardinal to identify and treat pregnant and breastfeeding women living with HIV and through them facilitate early infant diagnosis (EID) and Family Testing. Strengthening PMTCT integration in MNCH ultimately reduces the number of new infections among infants and children while improving identification of missed children and their linkage to- and retention in treatment and care.

Tuberculosis (TB) is the most common opportunistic infection in people living with HIV, Including children and adolescents[xxv]. HIV infection increases the incidence of TB in children by a factor of around 8 and this increases with the degree of immunosuppression, however this risk is reduced by around 70% by ART, with protection increasing over 1 to 2 years[xxvi]. Clinics, corners and community programmes providing TB services are important entry points to identify people, children and adolescents living with HIV and through them facilitate Family Testing. In addition, WHO recommends TB preventive therapy for children and adolescents living with HIV who do not have active TB and/or are in contact with a case of TB[xxvii]. It is therefore important to integrate TB screening and referral as a component of the package of services that are offered during Family Testing.

Children living with HIV also commonly present with severe acute malnutrition (SAM). HIV prevalence is high in children with SAM in sub-Saharan Africa and children living with HIV are at significantly increased risk of mortality[xxviii]. According to WHO, "in the context of SAM, there is strong justification for routinely testing all children for HIV, in order to identify a population that would benefit from a highly effective intervention, namely ART"[xxix]. As with TB, clinics and community programmes providing SAM management services are important entry points to identify infants and children living with HIV and through them facilitate Family Testing. It is also important to integrate nutritional screening and referral as a component of the package of services that are offered during Family Testing.

There is growing evidence on the negative impact of maternal HIV viremia[xxx] and exposure to maternal antiretroviral drugs in utero on the developmental milestones of HIV exposed uninfected infants[xxxi]. In addition, there is evidence that both HIV-infected and HIV-exposed uninfected infants experience poor working memory function affecting their learning capacity and development potential[xxxii]. Interventions such as cognitive rehearsal, home-based stimulation and parental support have been found to be effective in children with developmental delays and learning difficulties. Based on this, developmental milestone screening and referral to early childhood development programmes should be integrated as a component of the package of services that are offered during Family Testing.

The needs of families living with and affected by HIV go beyond health. During Family Testing, it may be observed that children are not enrolled in school, that water and sanitation hygiene (WASH) conditions are sub-optimal or that there are situations of violence, poverty or social exclusion. The necessary linkages should be made to the required social services (i.e. education, WASH, child protection and social welfare for the family to benefit from the support available in that context e.g. cash transfers).

3.10 Activating Family Testing

Organize a high-level press event to launch Family Testing

A high-level media event will aid to garner high visibility and momentum for Family Testing. This high-level event could include a dialogue among political, religious and civic leaders on the theme of the campaign. Wide coverage by media will give high visibility to the event and be a powerful way to:

- Make Family Testing a public health issue;

- Challenge attitudes and behaviors across society that prevent Family Testing and access to HIV care in general;
- Be a vehicle to inform people living with HIV of the benefits of Family Testing;
- Catalyze initiatives of different organizations and individuals to make them a coordinated, multilevel and multi-sectoral action;
- Build a critical mass for change by bringing together people from diverse backgrounds and creating opportunities for mutual learning, networking, scaling up and movement building;
- Contribute to the development of leadership skills among event organizers and supporters as well as give a voice to women, men, girls and boys (especially those living with HIV) as advocates for Family Testing and agents of change.

To adequately prepare for the press event, a media briefing for personnel from print, radio and television organizations should be held.

Subnational press events at district or county or LGA level should occur concurrently or subsequently, complemented by local and community media coverage.

Extend/ Expand your reach through social media

Develop a Family Testing hashtag (such as #familytestingforhealthyfamilies) to engage people through Facebook, Twitter and Instagram. Where possible, link the hashtag to feature stories and visuals.

Activate feedback mechanisms for bottlenecks such as stock-outs, refusals or capacity constraints

This can be done using u-report, m-health platforms or other available service delivery and program management technologies. Ensuring feedback mechanisms are in place will allow for quick remediation when challenges arise.

3.11 Monitoring and Evaluating for Learning: Taking an evaluative monitoring approach

Monitoring

Monitoring will help "check the pulse" of the Family Testing model over time. Monitoring will focus very much on the activities implemented on the ground and will help service providers address implementation-related questions such as the following:

- How many training sessions on interpersonal communication have been held over the last month?
- How many community members have completed the training sessions held at the health center over the last month?
- When did these training sessions take place? Did they happen as scheduled?
- How many health facilities have initiated Family Testing over the last month?

Nonetheless, all the previous 10 steps need to be monitored in order to make sure that the programme is on track, to make the necessary adjustments and to ensure the success and sustainability of the family testing service programme.

However, **monitoring is not just about checking whether the activities are being implemented as planned. Monitoring is also about measuring the results of all these activities.** Service providers would not need to wait for an external evaluation team to tell them whether the Family Testing model is being successful or not. With appropriate tools, service providers can measure how much they are contributing to **3 CHANGES**.

If we take the example of **CHANGE 1 (More Families Are Accepting Testing)**, service providers could start measuring the progress of their activities from the very first month of implementation by answering the following question: What has been the number of families accepting to get tested over the last month?

Monitoring Change 1. Measure if more families are accepting to get tested
Indicator: Family Testing acceptance rate Numerator: Number of identified PLWHIV accepting Family Testing Denominator: Number of identified PLWHIV offered Family Testing Set the baseline and target at the onset of activities

Likewise, service providers could measure how much they are contributing to **CHANGE 2 (More Children Living with HIV** are being identified) by answering the following question: **How many new Children Living with HIV were identified on site over the last month?**

Monitoring Change 2. Measure if we are finding more Children living with HIV (CLWHIV)
Indicator: Positivity rate among children aged <1, 1-4, 5-9, 10-14 and 15-19 Numerator: Number of children who tested positive aged <1, 1-4, 5-9, 10-14 and 15-19 Denominator: Number of children tested aged <1, 1-4, 5-9, 10-14 and 15-19 Set the baseline and target at the onset of activities

Lastly, service providers could also measure how much they are contributing to **CHANGE 3 (More Children Living with HIV** are starting treatment) by answering the following question: **How many new Children Living with HIV started treatment over the last month?**

Monitoring Change 3. Measure if we are treating more CLWHIV
Indicator: Treatment initiation rate among children aged <1, 1-4, 5-9, 10-14 and 15-19 Numerator: Number of children who tested positive and were started on treatment aged <1, 1-4, 5-9, 10-14 and 15-19 Denominator: Number of children who tested positive aged <1, 1-4, 5-9, 10-14 and 15-19 Set the baseline and target at the onset of activities

Monitoring is a routine activity that is expected to take place on a regular basis. Therefore, by comparing the number of families accepting to get tested every month **(CHANGE 1),** services providers will be able to measure trends (is the number going up or down?) and, depending on how well the activities on the ground are going, highlight possible issues for further exploration.
Please refer to the annex for a detailed monitoring framework for Family Testing.

Evaluation complements what monitoring does. Through evaluation, service providers will be able to understand **why, how and where** the **3 CHANGES** are happening or not. But, even more importantly, evaluation will assist service providers in understanding for whom and under what circumstances those 3 CHANGES are happening or not. Evaluation is different from monitoring: it entails a judgement of the quality and impact of interventions on the ground.

Here are some examples of evaluation questions applicable to all the 3 CHANGES

- **CHANGE 1**: More families accept to get tested
- **CHANGE 2**: More Children Living with HIV are identified
- **CHANGE 3**: More new Children Living with HIV start treatment

Evaluation Questions :

- To what extent has the number of families accepting to get tested/number of Children Living with HIV identified/number of new Children Living with HIV starting treatment":

-Increased,

-stay the same, or

-decreased?

- With respect to the families accepting or not accepting to get tested or with respect to the children identified who started or did not start treatment, what are some of their common characteristics ethnic group, age, religion, literacy level, socio-economic status, sector/ward/village of residence, etc.)?
- If Change 1/Change 2 and/or Change 3 took place, what were the contextual factors that enabled them the most? Some of these factors that could have influenced positively the course of events are listed in table 4. Additional contextual factors can be explored.

Table 4: Review of contextual factors that could have positively impacted results

Community Enablers
- Positive advocacy from community, traditional, religious and civic leaders - Active networks of people living with HIV and civil society - Active and accessible peer-support groups - Empowered and trained community health workers - Others ?

Health System Enablers
- Family Testing policy, guidance and tools - Regular supervision and mentorship - Strong supply chain management for testing commodities and antiretroviral drugs - Testing quality control/quality assurance systems - Skills building for disclosure. - Task shifting and equipping CHWs with training & tools to conduct counselling and testing - Functional referral systems - Linkages to social welfare and gender-based violence programs - Others ?

- **If Change 1/Change 2 and/or Change 3 DID NOT take place as expected, what were the contextual factors that hindered them the most? Some of these factors that could have influenced negatively the course of events are listed in table 5. Additional contextual factors can be explored.**

Table 5: Review of contextual factors that could have negatively impacted results

1. Individual Barriers
Parental Fear of inadvertent disclosure/stigma
Low parent awareness of benefits
Unwillingness of parents due to fear, guilt, blame
Logistical challenges of bringing children/family to the facility (transport cost, time off work)
Others ?
2. System Barriers
Inconsistent inquiry & offering of testing
Health worker overwhelm with increased testing load
Poor linkages to treatment/poor referral systems
HIV testing commodities/ARV stock outs
Others ?

- **With respect to the work done in the health facility, referring to table 6, the activities that were the most and/or least successful in achieving the 3 CHANGES can be assessed.**

Table 6: Review of practices influencing results at health facility level

Health Facility Enablers	Worked Well	Did NOT work so Well
1. Appointment and card filing/retrieval systems to shorten waiting time and enhance client satisfaction 2. Multiple-entry point testing through various health service entry points to complement family index case testing 3. Patient follow-up using both community workers and health facility workers supported by peer support groups (mentor mothers, adolescent youth groups) 4. Linkage to other services such as TB family screening, nutritional family screening, early childhood development (ECD) services, cash transfers and supplementary food programs 5. Others ?		

- Finally, undertake a review of what the unexpected consequences (positive or negatives) of implementing Family Testing in the health facility or community were?

Making a strategic use of monitoring and evaluation on a more systematic basis will enhance the quality and effectiveness of Family Testing management and implementation. This combination of monitoring and evaluation is referred to as "evaluative monitoring". This new approach will ensure a more continued assessment of the progress made on the ground with respect to the envisaged targets and cost as well as with respect to the expected effectiveness, efficiency and sustainability. Furthermore, for the use of this new approach to be effective, both the service providers and the Family Testing managers should be open to use the monitoring and evaluation data to inform course correction and re-alignment of both implementation and resource allocation on a continued basis.

The success of this approach will also depend on the quality of data sources and data collection methods. A specific effort should be made to ensure the collection of both quantitative data (e.g. obtained from district health information systems) and qualitative data (e.g., obtained from case studies, focus group discussions, direct observations, exit interviews). Both quantitative and qualitative methods should leverage new technologies. Thanks to the adoption of this innovative approach, it will be possible to monitor changes more closely during implementation while building the lessons learnt into routine systems strengthening.

For it to fulfill its objectives, this approach should ideally be planned and adopted before the start of the Family Testing implementation. While service providers will have the primary responsibility for the collection of monitoring and evaluation data, it is recommended that field visits, clients satisfaction surveys and focus group discussion with some of the expected beneficiaries be organized with the help of external evaluation professionals (e.g. consultants and experts). The involvement of an external evaluator or of an evaluation team would allow verifying implementing partners' assertions about the project impact and would enhance accountability not only to donors (vertical accountability) but also to the population groups that are expected to benefit from Family Testing (horizontal accountability). An evaluation would also contribute to assessing whether the original assumptions underlying the Family Testing model hold or not in reality. To this end, it would be good to allocate resources to conduct an independent evaluation in the future (e.g. a mid-term evaluation to be undertaken half-way through implementation).

Key Considerations to Sustain the 3 CHANGES

At Family Level:

Responsive male parenting by:

- Reaching men with key messages in male spaces

Improved family awareness on access and benefits for Family Testing through:

- M-health/U-report communication platforms
- Workplace and schools awareness programs
- High school sexual and reproductive health curricula

At Community Level:

Continuous advocacy through:

- Empowered and accountable community leaders
- Community events to re-enforce key messages
- Community health worker recording and reporting tools integrating Family Testing

Strong social support systems through:

- Engaged and active NPLWHIV & peer groups
- Systematic social welfare linkages

At Health Service Level:

Integrate Family Testing in:

- Training materials for pre- and in-service
- Job aids
- Quantification and procurement mechanisms
- Quality assurance and supervisory tools
- National monitoring tools

Strengthen links with other line ministries for an integrated approach to family testing:

- Social welfare
- education

Share and learn by:

-Documenting experiences

-Peer to peer exchange

3.12 Exchanging knowledge by documenting and sharing experiences

"What is needed now for scaling this up is systematic knowledge exchange and learning. Peer-to-peer learning is a powerful tool once contextualized and adapted to the particular socio-economic and political context. Iterative learning with feedback loops can help in finding transformative solutions".[xxxiii]
There should be ongoing documentation of lessons learnt and best practice to inform continuous improvement and course correction. The capacity of health care providers and managers should be built to document their experiences and results through case studies, human interest stories and reports. Regular review, synthesis and collation of lessons learned, and best practices should be undertaken during program reviews and also widely disseminated through multiple channels including through webinars and communities of practice. This will enhance quality of services and beneficiary satisfaction as well as contribute to program results

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A peer mentor speaks with a HIV positive mother to follow up on how she's doing and what she needs at the Kaboko Clinic in Kasenga, Haut-Katanga Province, Democratic Republic of Congo

Annex

Monitoring framework for Family Testing

Dimension	Output Indicator	Numerator	Data Source	Denominator	Data Source	Means of verification	Frequency of reporting (if technological/m-health systems are available, frequency can be increased)	Level of reporting
Service Delivery	Index case Family Testing acceptance rate	No. of index cases accepting Family Testing		No. of index cases offered Family Testing			Monthly	Health facility, district and national
	Family Testing acceptance rate	No. of family members tested (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above)		No. of family members identified/ listed (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above)			Monthly	Health facility, district and national
	Family Testing positivity rate/ yield	Number of family members testing positive (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above)		Number of family members tested (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above			Monthly	Health facility, district and national
	Family Testing linkage rate	Number of family members testing positive who are linked to care & treatment (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above)		Number of family members testing positive (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above)			Monthly	Health facility, district and national
	Family Testing treatment initiation rate	Number of positive family members initiating treatment (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above)		Number of family members testing positive (by age band & sex: <1,1-4, 5-9, 10-14, 15-19, 20-24, 25-49, 50 and above)			Monthly	Health facility, district and national

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